



## TEXAS DEPARTMENT OF INSURANCE

### Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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## MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

### GENERAL INFORMATION

**Requestor Name**

Anesthesia Alliance of Dallas

**Respondent Name**

Travelers Indemnity Co

**MFDR Tracking Number**

M4-16-1323-01

**Carrier's Austin Representative**

Box Number 05

**MFDR Date Received**

January 19, 2016

### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "Please review the attached MDR request and determine payment is due to the provider for this service, as the carrier acknowledged receipt of the claim before the 95 day deadline which was 10/20/2015."

**Amount in Dispute:** \$131.32

### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "The billing received by the Carrier was dated 09-30-2015 and 10-12-2015, and received on 11-11-2015. Per Rule 102.4(h), documents sent electronically or by facsimile are deemed sent on the date received. The date received was 117 days after the date of service. As the billing received by the Carrier was not timely submitted within 95 days of the date of service, the Carrier properly denied reimbursement."

**Response Submitted by:** Travelers

### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 17, 2015	64415	\$131.32	\$131.32

### FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.20 sets out the requirements for medical bill submission by health care providers.
3. 28 Texas Administrative Code §134.230 sets out the reimbursement guidelines for professional medical

services.

4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - 29 – The time limit for filing has expired
  - P12 – Workers compensation jurisdictional fee schedule adjustment
  - W3 – Additional payment made on appeal/reconsideration

### **Issues**

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the rule applicable to reimbursement?
3. Is the requestor entitled to additional reimbursement?

### **Findings**

1. The insurance carrier denied disputed services with claim adjustment reason code 29 – "The time limit for filing has expired." 28 Texas Administrative Code §133.20(b) states in pertinent part, "Except as provided in Labor Code §408.0272(b), (c) or (d), a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided."

Review of the submitted information finds:

- Availity report generated on 11/11/2015 that shows;
  - Source/Payer Accepted
  - Date / October 9, 2015
  - Description / Payer acknowledge receipt of the claim

The carrier states in their response, "the Carrier did receive the billing electronically on 11-11-2015 through their e-billing vendor with a signature date of 10-12-2015. On the same date, the Carrier received a facsimile submission of the bill with the 09-30-2015 signature date. The electronic submission and hard copy submission can be delineated by the Carrier's e-billing vendor's electronic stamp on the upper left corner with the PSP Link Bill ID number."

The Division found insufficient evidence to support the respondents' statement as only the previously mentioned Availity report was found within the documentation submitted with this dispute. This report does state the claim was acknowledged by the correct carrier. Therefore, the carrier's denial is not supported. The services in dispute will be reviewed per applicable rules and fee guidelines.

2. 28 Texas Administrative Code §134.230 (c) states,

To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

- (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is (date of service yearly conversion factor).

The maximum allowable reimbursement is calculated as follows:

$$\begin{aligned} & (\text{DWC Conversion Factor} / \text{Medicare Conversion Factor}) \times \text{Participating AMOUNT} = \text{TX Fee Mar or} \\ & (56.2/35.7547) \times \$120.55 = \$189.48 \end{aligned}$$

3. The total allowable for the service in dispute is \$189.48. The requestor is seeking \$131.32. This amount is recommended.

### **Conclusion**

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$131.32.

## ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$131.32 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

### Authorized Signature

_____ Signature	_____ Medical Fee Dispute Resolution Officer	February , 2016 Date
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## YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**